Explanation Code and Explanation Code Crosswalk Instructions

EXPLANATION CODES

Explanation codes are printed on your Remittance Advice (RA) to identify the reason a claim line pended or rejected. Make sure you review all codes printed for each claim and read the description. Many of the codes have rebilling instructions or information that will assist you with future claims.

NOTE: Check your RA for messages on new explanation codes and changes to existing explanation codes.

PENDED AND REJECTED CLAIMS

When a claim is initially processed the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists edits which apply.

- **Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. Providers should review the definition of the codes to determine the reason for the rejection.
- **Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. An explanation code(s) followed by a P (e.g., 936P) prints in the explanation code column of the RA. These pended claims do not print again on the RA until the claim is paid or rejected, is pended again for another reason; or has pended for 60 days or longer.

When a claim is pended, wait until it is paid or rejected before another claim is submitted for the same service(s).

After a claim is pended it may pend again for a different reason. In that case, # symbol (#) prints in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

500-600 ARE HISTORY CODES

History edits are used to monitor frequency of services, combination of services, and payment limits on service provided to patients. A history explanation code prints in the following situations:

- The information on your claim is compared to information in our files on previously paid claims.
- The claim lines on your claim form are compared to each other.

700 SERIES ARE MANUAL REVIEW CODES

The 700 series of explanation codes are used when we manually reject your claim or make corrections/adjustments to the information on the claim line.

An R indicator with a 700 series code (e.g., 708R) means we manually rejected your claim for the reason indicated in the code description. An X indicator with a 700 series code means we have made a correction or adjustment to the claim line information.

EXPLANATION CODE CROSSWALK

The Explanation Code Crosswalk should be used in conjunction with your paper remittance advice (RA) to assist you with understanding why your claim was paid or rejected. The paper RA reports the HIPAA compliant Group Codes, Claim Adjustment Reason Codes, and Remittance Advice Remark codes along with the MDCH proprietary explanation codes to accurately inform providers about the status of their claims.

Group Codes – identify who is financially responsible for the amount that the payer is not reimbursing.

Claim Adjustment Reason Codes (CARCs) - communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.

Remittance Advice Remark Codes (RARCs) - relay service line specific information that cannot be communicated with a reason code.

Within the crosswalk, each MDCH proprietary explanation code has been aligned with an appropriate Group Code, CARC, and RARC. HIPAA requires payers to report valid standard codes in their electronic remittance advices. To allow consistency, MDCH is currently reporting these national codes within both the electronic and paper remittance advices.